(14)

No. 90-97

In The

Supreme Court of the United States

OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,
Petitioner,

vs.

NATIONAL LABOR RELATIONS BOARD, ET AL.,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF OF AMICUS CURIAE SUPPORTING PETITIONER AMERICAN HOSPITAL ASSOCIATION

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INTRODUCTORY STATEMENT

After more than 50 years of determining appropriate groupings of similarly-situated employees to be collectively represented as "bargaining units" on a case-by-case basis, the National Labor Relations Board ("the Board") announced in July 1987[1] that it would exercise its seldom-used quasi-legislative Administrative Procedure Act

[1]The initial notice of proposed rulemaking and notice of hearing appears at 52 Fed. Reg. 25,142 (1987) [hereinafter cited as *NPR I*]. The Board's second notice and revised proposed rule appears at 53 Fed. Reg. 33,900 (1988) [hereinafter cited as *NPR II*]. The Board's final action, entitled "Collective-Bargaining Units in the Health Care Industry; Final Rule," appears at 54 Fed. Reg. 16,336 (1989) (codified at 29 C.F.R. § 103.30(a)-(g) (1990)) [hereinafter cited as *Final Rule*].

("APA") rulemaking authority[2] to establish fixed bargaining units in the health care industry. Ultimately, the Board promulgated a rule which recognizes as appropriate in all acute care hospitals, regardless of differences in their size or operations, eight separate bargaining units. Ironically, the Board targeted the industry where it has the least experience[3] with bargaining unit determinations for its first experiment in making substantive law by quasi-legislative rulemaking. Even more ironically, the Board also targeted for its rigid *per se* approach a diverse and rapidly changing industry very much in need of flexible rules.

The Board's quasi-legislative rulemaking is subject to judicial review under the APA. As the discussion below shows, the final rule devised by the Board is arbitrary, capricious, an abuse of discretion and otherwise not in accordance with the law.

INTEREST OF AMICUS CURIAE

The California Association of Hospitals and Health Systems ("CAHHS") and the Hospital Council of Southern California ("HCSC") are non-profit associations whose members consist of hospitals and other health care institutions. CAHHS represents over 500 hospitals throughout the State of California. It is the largest state

[2]Section 6 of the National Labor Relations Act provides: "The Board shall have the authority from time to time to make, amend, and rescind, in the manner prescribed by Subchapter II of chapter 5 of Title 5 [the APA], such rules and regulations as may be necessary to carry out the provisions of this subchapter." 29 U.S.C.A. § 156 (West 1973).

[3]The Board has only exercised authority over non-profit health care institutions since 1974. *See* Pub. L. No. 93-360, 88 Stat. 395 (1974).

hospital association in the nation. HCSC represents over 200 hospitals in Southern California.

Most members of CAHHS and HCSC are acute care hospitals[4] subject to the Board's bargaining unit rule challenged in this action. If the rule is implemented, the acute care hospitals who are members of CAHHS and HCSC will face potentially catastrophic disruptions of patient care and serious interference with their capacity to flexibly and efficiently deliver health care services. CAHHS and HCSC submit this brief in an effort to protect the vital interests of their members in avoiding the serious problems associated with bargaining unit proliferation which were foreseen by Congress in 1974 and, until promulgation of the challenged rule, were prevented by decisions of the federal courts sharply limiting the number of acceptable bargaining units in the health care industry.

SUMMARY OF ARGUMENT

By promulgating a *per se* rule recognizing eight bargaining units as appropriate in all acute care hospitals, the Board has violated the National Labor Relations Act ("NLRA" or "the Act"). First, it has deprived such institutions of the right conferred by Section 9(b) of the Act to establish bargaining units according to their own circumstances "in each case." Additionally, it has violated the congressional admonition to avoid proliferation of bargaining units in health care institutions.

Moreover, an examination of the rulemaking record shows that the Board went through tortuous gyrations to justify its establishment of eight mandatory units and its

[4]"Acute care hospital" is defined for purposes of the challenged rule at 29 C.F.R. § 103.30(f)(2) (1990).

abandonment of case-by-case adjudication. To achieve this result, the Board (1) reversed its strongly held conviction, announced just seven years earlier, that both statutory requirements and policy reasons preclude a *per se* approach to bargaining unit determinations; (2) labeled as substantially uniform and therefore subject to a *per se* approach an industry which, just three years earlier, it considered too diverse for generalizations; (3) scuttled all previously applied standards in favor of an "empirical" approach with no discernable standard; (4) dismissed as inconsequential or irrelevant factors which it previously had considered dispositive, and vice versa; (5) attempted to circumvent the legislative history of the 1974 health care amendments to the Act by attacking Congress' conclusions with questionable statistics; and (6) ultimately established bargaining unit configurations based on the perceived desires of employees and labor organizations, criteria which may not lawfully be given controlling effect. Accordingly, the Board's promulgation of the eight bargaining unit rule was arbitrary, capricious, an abuse of discretion and not otherwise in accordance with law.

ARGUMENT

I. Historical Background

A. The 1974 Amendments

In 1974, the NLRA was amended to extend coverage to non-profit hospitals. Pub. L. No. 93-360, 88 Stat. 395 (1974). The dominant theme in the 1974 amendments and their legislative history was Congress' intent to minimize

strikes and labor disputes in the health care industry and the accompanying disruption of patient care.[5]

Congress' intent to minimize labor disruptions in the health care industry was evident in its consideration of appropriate bargaining units. During the hearings leading to passage of the 1974 amendments, the concern repeatedly was expressed that unit fragmentation in health care institutions would increase labor disputes and adversely affect patient care. *See* 1 C. MORRIS, THE DEVELOPING LABOR LAW 437 & n.130 (2d ed. 1983) (*citing* Subcomm. on Labor of the Senate Comm. on Labor and Public Welfare, 93d Cong., 2d Sess., *Legislative History of Non-Profit Hospitals under the National Labor Relations Act* (1974)). Congress specifically directed in the Senate and House committee reports that "[d]ue consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry." *Id.* (*citing* S. Rep. No. 93-766, 93d Cong., 2d Sess. 5 (1974), and H.R. Rep. No. 93-1051, 93d Cong., 2d Sess. 7 (1974)). The committee reports cited with approval prior Board cases reflecting a trend toward broader units in the health care industry. *Id.* Co-sponsors of the 1974 amendments emphasized in debates that unit proliferation in the health care industry would lead to jurisdictional disputes, work stoppages, wage whipsawing, and higher medical costs to the public. 120 Cong.

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[5]For example, the 1974 amendments provide special deadlines for filing notices of termination and modification of health care collective bargaining agreements prior to expiration and for special advance notification to the Federal Mediation and Conciliation Service of the intent to strike, picket, or engage in other concerted refusal to work. *See* NLRA §§ 8(d)(A)-(C) and 8(g), 29 U.S.C.A. §§ 158(d)(A)-(C) and 158(g) (West 1973 & Supp. 1990).

Rec. 12,944-45, 13,559, 22,949 (1974) (statements of Sen. Taft and Rep. Ashbrook).

B. The Board's Post-Amendments Nonacquiescence

In the years since the 1974 amendments, there has been a protracted struggle between the Board and the courts resulting from the Board's tendency to ignore Congress' nonproliferation directive and the courts' almost uniform insistence on adherence to the legislative intent.[6] The Courts of Appeals repeatedly have rejected both (1) the Board's attempts to make inflexible, *per se* predeterminations that certain separate bargaining units (chiefly units of registered nurses and skilled maintenance workers) are appropriate, and (2) the Board's failure to adhere to the congressional directive against unit proliferation. The Board has more than proved the validity of Congress' concern that, if left to its own devices, it would ignore the public's special interest in uninterrupted and low-cost delivery of health care services, and would find the same

[6]*See NLRB* v. *Walker City Medical Center, Inc.*, 722 F.2d 1535 (11th Cir. 1984); *Watonwan Memorial Hospital, Inc.* v. *NLRB*, 711 F.2d 848 (8th Cir. 1983); *NLRB* v. *Frederick Memorial Hospital, Inc.*, 691 F.2d 191 (4th Cir. 1982); *Presbyterian St. Luke's Medical Center* v. *NLRB*, 653 F.2d 450 (10th Cir. 1981); *Mary Thompson Hospital, Inc.* v. *NLRB*, 621 F.2d 858 (7th Cir. 1980); *Allegheny General Hospital* v. *NLRB*, 608 F.2d 965 (3d Cir. 1979); *NLRB* v. *Mercy Hospital Ass'n*, 606 F.2d 22 (2d Cir. 1979), *cert. denied*, 445 U.S. 971 (1980); *NLRB* v. *Sweetwater Hospital Ass'n*, 604 F.2d 454 (6th Cir. 1979); *NLRB* v. *St. Francis Hospital of Lynwood*, 601 F.2d 404 (9th Cir. 1979). One isolated decision of the District of Columbia Circuit found the nonproliferation statements in the legislative history of the 1974 amendments to be of no legal effect. *See Electrical Workers IBEW Local 474* v. *NLRB*, 814 F.2d 697 (D.C. Cir. 1987). The decision of the District of Columbia Circuit is contrary to the decisional law of every other circuit except the First and Fifth Circuits, which have not yet ruled on the issue.

type of bargaining units appropriate in a health care facility as an industrial plant. *See Allegheny General Hospital*, 239 N.L.R.B. 872, 883 (1978) (Penello dissenting), *enforcement denied*, 608 F.2d 965 (3d Cir. 1979).

The great majority of decisions reversing the Board's bargaining unit determinations involve rejections of separate bargaining units for registered nurses and skilled maintenance employees.[7] Shortly after the 1974 amendments, the Board established a presumption that units of registered nurses were appropriate, and then proceeded to treat the presumption as irrebuttable. The irrebuttable presumption promptly was rejected by the courts. *See NLRB* v. *St. Francis Hospital of Lynwood*, 601 F.2d 404 (9th Cir. 1979). In *St. Francis of Lynwood*, the Ninth Circuit ruled that the congressional directive against unit proliferation required a "disparity of interests" test, focusing on whether differences in interests among employees precluded representation in the same collective bargaining unit. Under the disparity of interests test, all professional employees would be included in the same unit unless the disparity of interests was great enough to justify exclusion.[8]

[7]Ironically, the rule which is challenged here makes mandatory, among the eight recognized units, separate units of registered nurses and skilled maintenance employees. *See infra* note 13.

[8]In other industries, in order to place employees with similar interests together in the same unit, the Board has applied a "community of interests" test by examining such factors as similar occupations, common supervision, common job duties and conditions of employment, interchange of employees, day-to-day contact among employees, and other issues which affect the workplace environment. In any given workplace, there are likely to be multiple overlapping units which could be found appropriate under the community of interests standard. *See generally* 1 C. MORRIS, THE DEVELOPING LABOR LAW 416-17 (2d ed. 1983).

The Board did not acquiesce in the *St. Francis of Lynwood* decision. It did revert to a procedure wherein it would decide appropriate bargaining units based on the evidence developed in each case. *Newton-Wellesley Hospital,* 250 N.L.R.B. 409 (1980). It continued, however, to decide health care bargaining unit cases based on the "community of interests" standard used for other industries, and asserted that the Ninth Circuit's disparity of interests test was "encompassed" within the community of interests test. *Id.* at 411-12. Two years later, the Ninth Circuit rejected the Board's argument, reaffirmed its instructions to the Board, and again denied enforcement of Board certification of an all registered nurse unit. *NLRB* v. *HMO Int'l,* 678 F.2d 806, 812 (9th Cir. 1982).

The Fourth Circuit joined the Ninth Circuit by rejecting a registered nurse unit and the Board's application of the community of interests test in *NLRB* v. *Frederick Memorial Hospital, Inc.,* 691 F.2d 191 (4th Cir. 1982). The Tenth Circuit also rejected a registered nurse unit and joined the Ninth Circuit in adopting the disparity of interests test. *Presbyterian-St. Luke's Medical Center* v. *NLRB,* 653 F.2d 450, 457 (10th Cir. 1981).[9]

The courts also repeatedly have rejected the Board's attempts to approve separate bargaining units for skilled maintenance employees. *See Mary Thompson Hospital, Inc.* v. *NLRB,* 621 F.2d 858, 864 (7th Cir. 1980); *Allegheny General Hospital* v. *NLRB,* 608 F.2d 965, 970 (3d Cir. 1979); *NLRB* v. *Mercy Hospital Ass'n,* 606 F.2d 22 (2d

[9]Three other circuits have insisted that the Board must clearly apply the congressional admonition against undue unit proliferation. *NLRB* v. *Walker City Medical Center, Inc.,* 722 F.2d 1535 (11th Cir. 1984); *Watonwan Memorial Hospital, Inc.* v. *NLRB,* 711 F.2d 848 (8th Cir. 1983); *NLRB* v. *Sweetwater Hospital Ass'n,* 604 F.2d 454 (6th Cir. 1979).

Cir. 1979), *cert. denied,* 445 U.S. 971 (1980); *NLRB* v. *West Suburban Hospital,* 570 F.2d 213, 216 (7th Cir. 1978).

Meanwhile, the Board itself waffled over the issue of appropriate bargaining units in the health care industry and the community of interests versus the disparity of interests standard. In *St. Francis Hospital,* 265 N.L.R.B. 1025 (1982) [hereinafter cited as *St. Francis I*], a divided Board adhered to the position that the community of interests and disparity of interests tests are essentially the same. In *St. Francis Hospital,* 271 N.L.R.B. 948 (1984) [hereinafter cited as *St. Francis II*], finally agreeing to adhere to the congressional admonition against bargaining unit proliferation, another divided Board vacated *St. Francis I* and adopted the disparity of interests standard. Using the disparity standard in that case, it denied certification of a separate unit of maintenance employees. Using the disparity standard in subsequent cases involving petitions for registered nurse units, the Board uniformly held such units to be inappropriate. *See Keokuk Area Hospital,* 278 N.L.R.B. 242 (1986); *North Arundel Hospital Ass'n,* 279 N.L.R.B. 311 (1986); *Middletown Hospital Ass'n,* 282 N.L.R.B. 541 (1986); *St. Vincent Hospital and Health Center,* 285 N.L.R.B. 365 (1987).

C. The Board's Section 6 Rulemaking

In 1987, apparently frustrated by the rejection of its disparity of interests approach in an aberrant decision of the District of Columbia Circuit,[10] the Board decided to

[10]*Electrical Workers IBEW Local 474* v. *NLRB,* 814 F.2d 697 (D.C. Cir. 1987). *See supra* note 6 and accompanying text. On remand, the Board expressed its strong disagreement with the District of Colum-

(Continued . . .)

engage in rulemaking pursuant to Section 6 of the Act, 29 U.S.C.A. § 156 (West 1973). The Board elected this approach instead of petitioning for Supreme Court review.[11]

In July 1987, the Board issued its first notice of proposed rulemaking (*NPR I*). The Board proposed a rule providing that in health care institutions, absent undefined "extraordinary circumstances," only bargaining units spelled out in the rule would be recognized by the Board. The proposed rule governed acute care hospitals and nursing homes; bargaining units in other types of health care institutions would continue to be determined by adjudication on a case-by-case basis. In *NPR I*, the Board proposed to recognize six bargaining units in large acute care hospitals (more than 100 patient beds) and four bargaining units in small acute care hospitals. *See*

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[10]*(. . . Continued)*

bia Circuit's interpretation and continued to assert its adherence to the disparity of interests test as an exercise of its "reasoned discretion," whether or not the congressional admonition was a binding directive. *St. Francis Hospital*, 286 N.L.R.B. 1305, 1306 (1987) [hereinafter cited as *St. Francis III*]. *See also St. Vincent Hospital and Health Center*, 285 N.L.R.B. at 367-368.

[11]The decision to engage in rulemaking did not have the concurrence of the full Board. Member Johansen maintained throughout the process that establishing appropriate bargaining units by APA rulemaking contravenes the Board's obligation to decide such issues on a case-by-case basis pursuant to Section 9(b) of the Act, 29 U.S.C. § 159(b), and that the appropriate method for resolving the conflicting judicial decisions is to "submit these questions to the Supreme Court." *NPR II*, 53 Fed. Reg. at 33,935. *See also Final Rule*, 54 Fed. Reg. at 16,347.

NPR I, 52 Fed. Reg. 25,142.[12] Notwithstanding its recognition of units which had been found inappropriate in adjudicated cases applying the disparity of interests standard (*e.g.*, registered nurse units), the Board purported in *NPR I* to continue applying that standard. *See NPR I*, 52 Fed. Reg. at 25,146.

On September 1, 1988, the Board issued a second proposed rule (*NPR II*) which departed substantially from the original proposed rule. The second proposed rule eliminated the distinction between small and large acute care hospitals and specified eight units for all acute care hospitals regardless of their size or the nature of their operations.[13] *See NPR II*, 53 Fed. Reg. 33,900. In making this proposal, the Board asserted that it was abandoning all previous "doctrinal formulations," including the community of interests and disparity of interests standards, in favor of an "empirical" approach. *See NPR II*, 53 Fed. Reg. at 33,904-906.

On April 18, 1989, the Board issued the final rule, which is codified at 29 C.F.R. § 103.30(a)-(g) (1990). The final rule establishes eight[14] mandatory bargaining units for acute care hospitals regardless of size or operations

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[12]For large hospitals, the mandatory units were: (1) registered nurses, (2) physicians, (3) all other professionals, (4) all technical employees, (5) service, maintenance and clerical employees, and (6) guards. For small hospitals the mandatory units were: (1) all professionals, (2) all technical employees, (3) all service, maintenance and clerical employees, and (4) all guards. *NPR I*, 52 Fed. Reg. 25,142.

[13]The eight units for all sizes of acute care hospitals were: (1) registered nurses, (2) physicians, (3) all other professionals, (4) all technical employees, (5) skilled maintenance employees, (6) business office clericals, (7) guards, (8) all other nonprofessionals. *NPR II*, 53 Fed. Reg. 33,900.

[14]The eight units in the final rule are the same eight units listed at note 13, *supra*.

and exempts only hospitals that are primarily nursing homes, psychiatric hospitals, or rehabilitation hospitals. The rule permits "various combinations" of the eight units "if sought by labor organizations." Otherwise, the final rule provides for deviations from the eight units only in "extraordinary circumstances" and circumstances where there are existing non-conforming units. The rule itself does not define "extraordinary circumstances" other than to state that units of five or fewer employees shall constitute an "extraordinary circumstance." However, in the commentary accompanying the rule, it is clear that except for this five-employee threshold, acute care hospitals are effectively foreclosed from asserting that any extraordinary circumstances exist.[15]

II. The Rule Violates The National Labor Relations Act

In reviewing rulemaking under the APA the courts will "hold unlawful and set aside agency action . . . found to be . . . arbitrary, capricious, an abuse of discretion, *or otherwise not in accordance with law.*" 5 U.S.C.A. § 706(2)(A) (West 1977) (emphasis added). Furthermore, on review, a court must "decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of the agency action." 5 U.S.C.A. § 706 (West 1977). The

[15]In *NPR II*, the Board defined the scope of the "extraordinary circumstances" exception by setting forth what would *not* qualify. After listing six specific factors that the Board deemed too "ordinary" to qualify, it stated that it would not consider any evidence within "the range of circumstances revealed at the [rulemaking] hearings and known to the Board from more than 13 years of adjudicating cases in this field . . . ." *NPR II*, 53 Fed. Reg. at 33,933. In the commentary accompanying the final rule, the Board reaffirmed this intent. *Final Rule*, 54 Fed. Reg. at 16,345.

Board's action here is not in accordance with the National Labor Relations Act.

A. The Rule's Establishment Of Mandatory Bargaining Units On An Industry-Wide Basis Violates Section 9(b) Of The Act

Section 9(b) of the Act, 29 U.S.C.A. 159(b) (West 1977), requires that the Board determine the unit or units appropriate for collective bargaining "in each case." The petition for certiorari filed by the American Hospital Association ("AHA") contains a detailed analysis of Section 9(b) and its legislative history. *See* AHA's *Petition for Writ of Certiorari*, at 12-21 [hereinafter cited as *AHA Petition*]. Those arguments need not be repeated here.

It should be noted, however, that AHA's interpretation of Section 9(b) finds further support in the continued reluctance of Congress to establish *per se* appropriate bargaining units. Since adopting the "in each case" language in 1935, Congress twice has rejected legislation which would have interfered with case-by-case unit determinations. When Congress deliberated over the 1974 amendments, it rejected S. 2292, introduced by Senator Taft, which would have specified four fixed bargaining units in the health care industry. *See St. Francis of Lynwood*, 601 F.2d at 411. In 1978, Congress considered and failed to pass S. 2467, which would have required the Board to embrace rulemaking in several areas, including an elaboration of appropriate bargaining units. *See NPR I*, 52 Fed. Reg. at 25,144.

Moreover, on a number of occasions prior to initiating the current rulemaking, the Board has expressed, in the strongest possible terms, that unit determinations must be carefully tailored to the facts of each individual case.

In so doing, it has relied both on its interpretation of Section 9(b) and on policy considerations.

For example, in *Kalamazoo Paper Box Corp.*, 136 N.L.R.B. 134 (1962), the Board said:

> Because the scope of the unit is basic to and permeates the whole of the collective-bargaining relationship, each unit determination, in order to further effective expression of the statutory purposes, must have a direct relevancy to the circumstances within which collective bargaining is to take place. For, if the unit determination fails to relate to the factual situation with which the parties must deal, efficient and stable collective bargaining is undermined rather than fostered.

136 N.L.R.B. at 137. The Board went on to state that an erroneous decision with respect to the scope of a bargaining unit:

> [w]ould result in creating a fictional mold within which the parties would be required to force their bargaining relationship. Such a determination could only create a state of chaos rather than foster stable collective bargaining and could hardly be said to "assure to employees the fullest freedom in exercising the rights guaranteed by this Act" as contemplated by Section 9(b).

136 N.L.R.B. at 139-40.

Subsequently, in *Newton-Wellesley Hospital,* 250 N.L.R.B. 409 (1980), the Board specifically acknowledged that a *per se* approach to bargaining units in the health care industry would violate Section 9(b). Agreeing in this regard with the decision of the Ninth Circuit in *St. Francis of Lynwood,* the Board stated:

> We have concluded that so much of the Board's St. Francis Decision as may be read to establish an

> irrebuttable presumption of the appropriateness of registered nurse units in all cases, without regard to particular circumstances, should be disavowed. Such a per se approach to unit determinations is inconsistent with the Board's Section 9(b) responsibility to decide "in each case" whether the requested unit is appropriate. Moreover, as the court [in *St. Francis of Lynwood*] pointed out, the legislative history of the 1974 health care amendments to the Act requires the Board to give due consideration to avoiding an unwarranted fragmentation of bargaining units in this industry. A per se rule could result in the Board's giving insufficient attention to this admonition of the Congress, and could permit the splitting of professional or other employees into separate units regardless of whether the particular circumstances warranted such a division.

250 N.L.R.B. at 411.

Of course, the Board has now discarded its earlier pronouncements by adopting just such a *per se* approach.[16] In so doing, it failed to distinguish or even acknowledge its previous interpretations.

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[16]The Board was not unanimous in its decision to abandon earlier precedent and interpretation. In dissenting from the final rule, Board member Wilford W. Johansen found that under the basic rules of statutory construction, the language of Section 9(b) ("the Board shall decide in each case") is mandatory rather than permissive. Johansen also stated his belief that the Board could not satisfactorily fulfill its statutory obligations under Section 9(b) by relegating the specialized, fact-oriented task of determining bargaining units to blanket rulemaking. Member Johansen noted that while rulemaking is

(Continued . . .)

This Court has final responsibility for interpreting Section 9(b). Because the Board's latest interpretation of the statute in its commentary to the rulemaking contradicts its own prior interpretation, it is entitled to very little deference. *See NLRB* v. *United Food and Commercial Workers Union,* 484 U.S. 112, 124 & n.20 (1987); *County of Washington* v. *Gunther,* 452 U.S. 161, 177-78 (1981). Moreover, reviewing courts must reject administrative constructions of statutes, whether reached by adjudication or rulemaking, where, as here, they are inconsistent with the statutory mandate or frustrate the policy that Congress sought to implement. *Federal Election Campaign Comm'n* v. *Democratic Senatorial Campaign Comm.,* 454 U.S. 27, 32 (1981).

B. The Rule Violates The Congressional Directive Against Unit Proliferation

Congress' purpose in enacting the 1974 amendments was to bring stability to an industry which provides the most essential of services to the American people. The 1974 amendments provided an orderly mechanism by which health care employees could engage in or refrain from engaging in self-organization through the Board's secret ballot election procedures rather than through confrontational recognitional disputes. Congress also

[16](... *Continued)*

desirable and appropriate in some areas, bargaining unit determination is not one of those areas.

> That is not only because the rules themselves are less flexible, but also because the nature of the evidence on which the rule is based is in turn more generalized — primarily anecdotal and statistical — and therefore lacks the quality of pertinent evidence regarding a specific situation which lies at the core of the decisional process.

Final Rule, 54 Fed. Reg. at 16,347.

sought to provide health care institutions and their patients with protection against the disruption of service that is likely to result from proliferation of bargaining units. *See* discussion *supra* at Section I(A), and *AHA Petition* at 21-26.

Congress found that unit proliferation brings with it a potential for severe operational disruptions from multiple organizing efforts, multiple negotiations, the issuance of multiple strike notices under Section 8(g) of the Act, and increased numbers of employees and patients who would be affected by potential strikes.

> In considering legislation to amend the Act, it was immediately recognized that the health care industry was unique and that disruptions caused by organizational drives and related activities at a hospital were a far more serious concern than at an industrial plant given the grave nature of medical care and the fact that "[h]ospital care is not storable."

St. Francis of Lynwood, 601 F.2d at 411.

In *St. Francis of Lynwood,* the Ninth Circuit held that a *per se* rule establishing a separate bargaining unit for registered nurses was "clearly" inconsistent with the congressional directive that the Board give "due consideration" to preventing proliferation of bargaining units in the health care industry and Congress' approval of the trend toward broader units. 601 F.2d at 414. *See also NLRB* v. *HMO International,* 678 F.2d 806, 812 (9th Cir. 1982). The new rule's mandatory registered nurse and skilled maintenance units also have been held to violate the nonproliferation directive by many other circuits, as well as by the Board, when applying standards implementing that directive. *See* discussion *supra* at Section I(B).

If enforced, the rule will impose on hospitals the bargaining unit proliferation and consequent harm which Congress instructed the Board to avoid and which has caused courts repeatedly to deny enforcement of the Board's orders in health care bargaining unit cases.

III. The Rule Is Arbitrary And Capricious

Agency action is not accorded the same degree of deference as legislation drafted by Congress. In *Motor Vehicle Mfrs. Ass'n* v. *State Farm Mutual Automobile Insurance Co.*, 463 U.S. 29, 43 & n.9 (1983), this Court rejected the argument that the arbitrary and capricious standard requires "no more than the minimum rationality a statute must bear in order to withstand analysis under the Due Process Clause."[17] A number of factors must be analyzed to determine whether agency action is arbitrary and capricious.

> Normally, an agency rule would be arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

Id. at 42.

Where the rule is a clear departure from past agency action, the degree of deference accorded to the agency is diminished and the agency must explain its reasoning.

[17]Review under the arbitrary and capricious standard is by no means a rubber-stamp process. "[U]nless we make the requirements for administrative action strict and demanding, [agency] expertise . . . can become a monster which rules with no practical limits on its discretion." *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 48-49 (citations omitted).

"An agency's view of what is in the public interest may change, either with or without a change in circumstances. But an agency changing its course must supply a reasoned analysis . . . ." *Id.* at 57. "[S]harp changes of agency course constitute 'danger signals' to which a reviewing court must be alert." *Natural Resources Defense Council, Inc.* v. *EPA*, 790 F.2d 289, 298 (3d Cir. 1986), *cert. denied*, 479 U.S. 1084 (1987) (citations omitted). *See also Sierra Club* v. *United States Army Corps of Engineers*, 772 F.2d 1043, 1046 (2d Cir. 1985) ("A change in something from yesterday to today creates doubt. When the anticipated explanation is not given, doubt turns to disbelief."). Even where agency action is supported by "substantial evidence," it may in another regard be arbitrary and capricious if it is an abrupt and unexplained departure from agency precedent. *Association of Data Processing* v. *Board of Governors of the Federal Reserve System*, 745 F.2d 677, 683 (D.C. Cir. 1984) (Scalia, J.).

A. The Board Did Not Explain Its Radical Departure From Prior Analysis And Interpretation

The rulemaking record contains many clear departures from past agency pronouncements that either lack or defy plausible explanation. For example, the Board has failed to provide any explanation for its total abandonment of the principles announced in *Newton-Wellesley Hospital*, 250 N.L.R.B. 409, 411 (1980), where it stated that the establishment of *per se* bargaining unit rules in the health care industry would violate both Section 9(b) and the nonproliferation mandate.

Another example is the Board's startling about-face in its characterization of the health care industry as homogenous. In 1984, the Board conceded that "[the] diverse nature of today's health care industry . . . precludes any generalization as to the appropriateness of any particular

bargaining unit." *St. Francis II*, 271 N.L.R.B. at 953 & n.39. As a result, the Board concluded that it was necessary to examine the particular facts (applying a disparity of interests test) in each case and decide, on the basis of those facts, the appropriate unit. There is nothing in the rulemaking record to establish that the health care industry has become *less* diverse than it was in 1984. In fact, the converse is true.[18] If such diversity required case-by-case consideration in 1984, it certainly requires it today. The Board has failed to articulate any reasons supporting this change in its position.

Moreover, the Board inexplicably declined to use either the community of interests test or the disparity of interests test in promulgating its final rule. In other words, for rulemaking, the Board chose to abandon *both* the traditional standard that it had used for other industries (and the health care industry prior to 1984) *and* the standard mandated by the Ninth and Tenth Circuits (and used by the Board in health care adjudication after 1984). Without a reasoned analysis supporting its departure from years of precedent, the Board stated that it would "attempt to avoid the doctrinal formulations utilized under adjudication" and substitute an "empirical" approach with no guiding standard.[19] *NPR II*, 53 Fed. Reg. at 33,905-906.

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[18] *See, e.g.*, Transcript, Hearing on Proposed Rulemaking on Collective Bargaining in the Health Care Industry, Sept. 14, 1987, at 3192-3197 (testimony of Duane Dauner, President of CAHHS).

[19] The Board did state that it would endeavor to create units reflecting "natural groupings" of health care employees. *NPR II*, 53 Fed. Reg. 33,905. It further purported to steer a course between groupings so large that organizing would be "exceedingly difficult" and so small that the congressional concerns regarding proliferation would be realized. *Id.*

Although the Board indicated that it would continue to rely on factors "similar" to those which guided previous adjudication (*id.* at 33,905), this simply is not true. Nowhere is the Board's complete abandonment of prior interpretation and analysis more evident than in its rulemaking with respect to registered nurses. In *NPR I*, the Board tentatively proposed a separate unit of registered nurses even though such a unit was completely inconsistent with the most recent three adjudications,[20] and the Board, as yet, had no additional evidence to support its departure from such precedent. To achieve this result, the Board radically altered its approach and emphasis in evaluating unit appropriateness. Thus, the Board cited several general factors as supporting the separateness of registered nurse units, most of which it had considered either *irrelevant* or *insubstantial* in prior adjudication, and some of which it previously had cited as, in fact, *favoring the combination of registered nurses with other professionals.*[21]

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[20] *See Middletown Hospital Ass'n*, 282 N.L.R.B. 541 (1986); *North Arundel Hospital Ass'n*, 279 N.L.R.B. 311 (1986); *Keokuk Area Hospital*, 278 N.L.R.B. 242 (1986).

[21] The factors cited by the Board in *NPR I* as support for a separate registered nurse unit are that nurses:

(a) Usually work "round the clock, 7 days a week";

(b) Have "constant responsibility for direct patient care";

(c) Are "subject to common supervision by other nurses";

(d) Share "similar education, training, experience and licensing that are not shared by other employees";

(e) Have more frequent contact with other registered nurses than with other professionals;

(f) Have "a lengthy history of organization, both professionally and for purposes of collective bargaining"; and

(Continued . . .)

In *NPR II*, the Board continued to assign entirely different significance to facts that had been available in prior adjudication with regard to registered nurse units. It continued to apply, in a manner entirely inconsistent with prior case law, the various factors that it had listed

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[21] *(. . . Continued)*

(g) Comprise "the largest group of professional employees at most health care facilities."

See NPR I, 52 Fed. Reg. at 25,146-147. *See also NPR II*, 53 Fed. Reg. at 33,911.

In *Keokuk Area Hospital*, 278 N.L.R.B. 242 (1986) and *North Arundel Hospital Ass'n, Inc.*, 279 N.L.R.B. 311 (1986), the Board considered and expressly dismissed factors (a), (b), (c), (d) and (e) as being insufficient to warrant separate registered nurse units. Indeed, with regard to factor (b), the Board stated that "the concept of direct versus indirect patient care *has long been rejected as a basis for making unit determinations in the health care industry.*" *North Arundel Hospital Ass'n*, 279 N.L.R.B. 311, 312 n.7 (*citing Bay St. Joseph Care Center*, 275 N.L.R.B. 1411 (1985)) (emphasis added). With regard to factors (c) and (d), the Board stated that such criteria are "equally applicable" to other professional employees, and "carried to its logical extreme," reliance thereon could result in separate bargaining units for each of the other professional classifications, "a result plainly at odds with the congressional directive against unit proliferation." *Id.* at 312. As to factor (g), the Board in adjudication found that the disparity in size between the registered nurse group and other professionals actually favored the establishment of a broader all-inclusive unit rather than allowing for a residual unit which is comprised of a relatively small proportion of the employer's professionals. *Id.* at 312, n.9. Finally, although factor (f) was not noted in the aforementioned cases, obviously such information about the history of organizing was available to the Board at the time. Accordingly, the Board's reliance upon such a factor in rulemaking further underscores its sudden and unexplained change of emphasis. Moreover, for the reasons set forth *infra* at Section III(B), pp. 25-29, the Board is statutorily precluded from ultimate reliance upon this factor.

in *NPR I*. *See NPR II*, 53 Fed. Reg. at 33,911-917 and cases cited *supra* note 20. In addition, it inexplicably reversed its position on other factors. For example, the Board found persuasive the fact that there is limited cross-training and interchange between registered nurses and other professionals because of licensing requirements. *NPR II*, 53 Fed. Reg. at 33,913. However, the Board had *expressly disclaimed* the relevance of this factor in prior adjudication. *See, e.g., North Arundel Hospital Ass'n*, 279 N.L.R.B. at 312. *See also St. Francis of Lynwood*, 601 F.2d at 419-20.

A further example of the Board's result-oriented fickleness is its treatment of evidence that hospitals are increasingly utilizing a "multi-disciplinary team" approach to patient care, which combines registered nurses with various other classifications. When evaluating such information on a case-by-case basis, the Board had found the use of such teams to be an important factor in denying separate registered nurse units. *See North Arundel Hospital Ass'n*, 279 N.L.R.B. at 312; *Keokuk Area Hospital*, 278 N.L.R.B. at 243. However, in rulemaking, the Board stated that hospitals unsuccessfully had relied upon the existence of such multi-disciplinary teams in attempting to defeat the 1974 health care amendments, and that "the team concept remains non-persuasive . . . ."[22] *NPR II*, 53 Fed. Reg. at 33,913.

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[22] Among the reasons cited by the Board for rejecting the team concept in rulemaking is that "the evidence at the [rulemaking] hearing established that many hospitals do not even use the team concept." *NPR II*, 53 Fed. Reg. at 33,913. If anything, this emphasizes the unsuitability of rulemaking for bargaining unit determinations. It undermines the Board's rationale for establishing mandatory bargaining units on an industry-wide basis; namely, that all acute care hospitals are essentially identical in all material

(Continued . . .)

An exhaustive recitation of the Board's unexplained departures from the analytical models of prior adjudication in this area would be impossible within the page limitations allowed for this brief. However, the rulemaking record is replete with them. Moreover, such inconsistencies are not confined to the Board's consideration of registered nurse units. Similarly disturbing discrepancies between adjudication and rulemaking appear in the Board's treatment of skilled maintenance units[23] and business office clerical units[24].

B. The Board Gave Controlling Weight To Irrelevant And Impermissible Factors

An agency's rule will be held arbitrary and capricious when it relies on factors which Congress did not intend to be part of the rulemaking equation. Such a transgression

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[23](. . . *Continued*)

respects. *See NPR I,* 52 Fed. Reg. at 25,145; *NPR II,* 53 Fed. Reg. at 33,903-904. Case-by-case adjudication clearly is necessary so that institutions which do have multi-disciplinary professional teams, such as North Arundel Hospital and Keokuk Area Hospital, can have the Board consider that factor. As previously noted, the Board's final rule precludes such consideration because the team concept, having already been considered in rulemaking and prior adjudication, would not be classified as an "extraordinary circumstance." *See* discussion of "extraordinary circumstances" exception *supra* note 15 and accompanying text.

[23]*Compare St. Francis Hospital,* 271 N.L.R.B. 948 (1984) [*St. Francis II*] and *St. Francis Hospital,* 286 N.L.R.B. 1305 (1987) [*St. Francis III*] (in which the Board found that the hospital's skilled maintenance employees were not entitled to a separate unit) *with* the rulemaking commentary in *NPR II,* 53 Fed. Reg. at 33,920-924.

[24]*Compare Baker Hospital,* 279 N.L.R.B. 308 (1986) (business office clerical employees not entitled to separate unit because there are no sharper than usual differences to demonstrate a disparity of interests between such employees and other non-professionals) *with* the commentary in *NPR II,* 53 Fed. Reg. 33,924-926.

occurred here. It is true, as asserted by the Board, that the rulemaking hearings produced some "empirical data" which may not have been available in prior adjudication. However, such data was used in a manner contrary to Congress' intent.

The data essentially was limited to two general categories: (1) that which addressed the validity of congressional concerns about strikes, jurisdictional disputes, wage leapfrogging, whipsawing and the like; and (2) that which showed the preferences of unions for organizing among certain groups of health care employees. *See NPR II,* 53 Fed. Reg. 33,908-910; 33,915; 33,922; 33,925.

The Board argues from the first category of data that experience shows congressional concerns about the effects of health care unit proliferation to have been unwarranted. *NPR II,* 53 Fed. Reg. 33,906-910. However, the value of such data, even assuming its completeness and accuracy, is extremely dubious. First, it is data based upon experience under a *different standard* from that which the Board now seeks to implement. In other words, it is data from a period in which *no bargaining unit proliferation in the health care industry existed.* From 1974 until 1984, the courts prevented the Board from allowing units to proliferate to the extent now provided by the final rule. And from 1984 to the present, the Board has stayed its own hand.

In any event, it is not the Board's province to second-guess Congress. Whether or not statistics *now* substantiate the concerns expressed in 1974, Congress *directed the Board to avoid proliferation of health care bargaining units.* The Board has no authority to repeal by rulemaking the legislative history of the 1984 health care amendments.

What remains, then, is the Board's compilation of data concerning the desires of unions (and allegedly their constituents) to organize into units which mirror the configuration established in the final rule. A review of the rulemaking record compels the conclusion that the Board gave controlling effect to this factor. That is because the only material and significant respect in which the rulemaking record differs from evidence produced in prior case-by-case adjudication is statistical evidence showing the extent to which unions have sought to organize in those units previously considered inappropriate (*i.e.*, registered nurses, business office clerical employees and skilled maintenance employees).[25]

The Act specifically prohibits the Board from giving controlling effect to such considerations. Section 9(c)(5) of the Act provides that "[i]n determining whether a unit is appropriate for the purposes specified in subsection (b) [of this section] the extent to which the employees have

[25]Attempting to justify its reliance on this factor, the Board stated that a legitimate consideration in bargaining unit determinations is whether organizing will be impeded by the size and composition of the unit. *NPR II*, 53 Fed. Reg. at 35,910. However, there is no evidence in the rulemaking record to support a conclusion that the units uniformly found appropriate in recent adjudication (applying the disparity of interests test) impeded organizing. Indeed, there is statistical evidence to the contrary. Testimony showed that during the period 1984-87 (when the Board was applying the disparity of interests test), unions in southern California won 11 of 15 hospital elections (73%) conducted in broader units, *i.e.*, all employees, all professional employees, or all non-professional employees. *See* Transcript, Hearing on Proposed Rulemaking on Collective Bargaining in the Health Care Industry, Sept. 15, 1987, pp. 3398-3431 (testimony of Arthur Sponseller, Vice President Human Resources, HCSC). By contrast, the percentage of elections won by unions in all industries nationwide has ranged between approximately 46% and 50%. *See* 1990 DAILY LAB. REP. (BNA) at A-6 (April 27, 1990).

organized shall not be controlling." 29 U.S.C.A. § 159(c)(5) (West 1973).

Construing this provision, this Court has held that while the Board may consider the extent of organizing as one factor, it may not be the controlling factor in bargaining unit determinations. *NLRB* v. *Metropolitan Life Insurance Co.*, 380 U.S. 438, 442 (1965). This Court has indicated that the Board must articulate reasons other than those prohibited by § 9(c)(5) and, where necessary, show that the extent of organizing was not the controlling factor by adequately distinguishing prior decisions which might create such an inference. *Id.*

Here, as noted, the Board has failed to establish any meaningful distinction between those adjudicated cases in which it found registered nurse, skilled maintenance and business office clerical units to be inappropriate and the current quasi-legislative rule in which it finds them to be *per se* appropriate, other than statistical evidence establishing the preference of unions to organize on that basis. Moreover, the Board revealed its hand in this regard with its very first announcement of rulemaking. In *NPR I*, the Board made reference to the "many hundreds of petitions for health care units" that it had received in the last thirteen years, and noted that the units requested generally fell into certain "predictable groupings" of employees. Among those predictable groupings were registered nurses. In the very same notice *and before any rulemaking hearings had taken place*, the Board proposed a rule for large hospitals (100 beds or more) which would mandate units consisting exclusively of registered nurses. As previously described, this was patently inconsistent not only with the decisions of the Courts of Appeals, but also with the decisions of the Board in *every individual case* in which it had considered the registered nurse unit

issue since 1984. The Board, at that point, clearly had *no basis* to depart from such precedent, other than the predictability that petitions would be filed for registered nurse units by the American Nurses Association's state affiliates and other organizations solely interested in organizing nurses.

The courts have not hesitated to deny enforcement of the Board's bargaining orders where it appears that the Board's unit determination contravened § 9(c)(5). *See, e.g., Westward-Ho Hotel Co.* v. *NLRB,* 437 F.2d 1110 (9th Cir. 1971); *NLRB* v. *Pinkerton's, Inc.,* 428 F.2d 479 (6th Cir. 1970); *NLRB* v. *Purity Food Stores, Inc.,* 354 F.2d 926 (1st Cir. 1965); *NLRB* v. *Capital Bakers, Inc.,* 351 F.2d 45 (3d Cir. 1965). There is no reason why a more deferential standard should apply when the bargaining unit determination is by APA rulemaking. *See Securities Industry Ass'n* v. *Board of Governors of the Federal Reserve System,* 468 U.S. 137, 143 (1984) (reviewing court must reject agency decisions inconsistent with statute whether reached by adjudication or by rulemaking).

The Board's conduct in this matter is strikingly similar to that which was found unlawful by the Ninth Circuit Court of Appeals in *Westward-Ho Hotel.* In that case, the court concluded that the Board had departed from prior decisions and standards by finding appropriate a unit limited to the hotel's kitchen employees, rather than a combined unit of kitchen, dining room and housekeeping employees. Although the Board had articulated seven reasons for its bargaining unit determination, the court concluded that six of them either could not be reconciled with prior decisions or were otherwise insupportable. The only remaining articulated rationale (the fact that no other labor organization had sought a broader unit) "strongly suggested" to the court that "the Board's action was controlled by extent of organization." *Id.* at 1115. As a result, the court refused to enforce the Board's order to bargain in the unit at issue.

In so doing, the court criticized the Board's view that any well-defined and functionally coherent group of employees that it finds to be appropriate must be upheld as such by a reviewing court.

> It is well-settled, of course, that the Board has a singularly wide discretion to determine appropriate bargaining units. *See, e.g., Packard Motor Car Co.* v. *NLRB,* 330 U.S. 485, 491-493, 67 S.Ct. 789, 91 L.Ed. 1040 (1947); *NLRB* v. *Hearst Publications, Inc.,* 322 U.S. 111, 132-135, 64 S.Ct. 851, 88 L.Ed. 1170 (1944). But the Board's discretion is not unlimited. Both the legislative history of § 9(c)(5) and the Supreme Court's decision in *NLRB* v. *Metropolitan Life Ins. Co., supra,* make it clear that the mere fact that the Board selects a unit consisting of a well-defined and functionally coherent group of employees does not by itself mean that its determination must be accepted by a reviewing court. We agree with *Local 1325, Retail Clerks Int'l Ass'n, AFL-CIO* v. *NLRB, supra,* at 1201, that *where prior Board decisions suggest that a unit determination was arbitrary or has been controlled by extent of organization, the Board must give reasons for its choice that effectively rebut the inference that it has acted improperly.*

Id. at 1115-1116 (footnote omitted) (emphasis added).

After examining the Board's decisions in similar cases and finding no adequate articulated basis for the different result, the court stated:

> [T]he Board's action here seems to be a retrogression to *Botany Worsted Mills,* 27 N.L.R.B. 687

> (1940), which appears from the legislative history of § 9(c)(5) to have been the kind of unit determination Congress intended to preclude. The House Report on § 9(c)(5) expressly criticized that decision as an example of a case in which "the Board *pretends to find reasons other than the extent to which the employees have organized as ground for holding such units to be appropriate.*" H.R. Rep. No. 245, 80th Cong., 1st Sess. 37 (1947).

Id. at 1116 (emphasis added).

In sum, the Board refused to explain its abrupt and complete departure from prior analysis and ultimately relied on impermissible factors to establish its *per se* eight bargaining unit rule. Accordingly, the rule is arbitrary and capricious.

CONCLUSION

The rule is an arbitrary and capricious exercise of power by the National Labor Relations Board which violates the National Labor Relations Act. The decision of the United States Court of Appeals for the Seventh Circuit should be reversed.

Respectfully submitted.

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